TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael D. Knott, DC

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-2309-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received an EOB denying payment for this bill for a designated doctor exam performed on May 31, 2014; the denial states the 'diagnosis was invalid for the dates of service reported'. However, this is incorrect, because the exam was performed as requested by the insurance carrier on the DWC32 in box #37.

We billed a total of $2,750.00 for these services. We have received no payment from your company. Please issue prompt payment in the amount of **$2,750.00** to settle this claim."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 3, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2014	Designated Doctor Examination (MMI/IR/EOI)	$800.00	$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §130.1 sets out the procedures for certification of Maximum Medical Improvement and Impairment Rating.
4. 28 Texas Administrative Code §127.10 sets out the general procedures for Designated Doctor Examinations.
5. 28 Texas Administrative Code §127.220 sets out the requirements for Designated Doctor Reports.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 14 – (146) Diagnosis was invalid for the date(s) of service reported.

Issues

1. Is the insurance carrier's reason for denial or reduction of payment supported?
2. What is the correct Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 14 – "Diagnosis was invalid for the date(s) of service reported." Review of the submitted documentation finds that the requestor billed with ICD-9 diagnostic codes 847.2, 847.00, and 841.9. ICD-9 Code 847.2 is defined as lumbar sprain and strain. ICD-9 Code 847.00 is defined as neck sprain and strain, unspecified. ICD-9 Code 841.9 is defined as sprain and strain of unspecified site of elbow and forearm. All of the billed diagnosis codes were valid for the date of service. Therefore the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area. (-b-) $150 for each additional musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the Impairment Rating of the upper extremity and used DRE method found in the AMA Guides 4th edition to find the Impairment Rating of the spine. Therefore, the correct MAR for this examination is $450.00.

   The requestor also billed CPT Code 99456-W6-RE to indicate an examination to determine the Extent of Injury. The narrative report does not support that this examination was performed, so the correct MAR for this code is $0.00.

3. The total allowable for the disputed services is $800.00. The insurance carrier has paid $0.00. Therefore the recommended reimbursement is $800.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	May 13, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.